

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 December 2005

CASE NO.: 2004-BLA-6748

In the Matter of
THEODORE BIONI,
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Cheryl Catherine Cowen, Esq.,
For the Claimant

George Stipanovich, Esq.,
For the Employer

Leon E. Pasker, Esq.,
For the Director

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's subsequent claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, as amended ("Act"), filed on July 22, 2003. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis (“black lung disease” or “coal worker’s pneumoconiosis” (“CWP”) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his first prior claim for benefits on October 14, 1980. ((Director’s Exhibit (“DX”)1). The claim was denied because the evidence failed to establish any of the elements of entitlement. (DX 1). No further action was taken on the claim and it is considered closed.

The claimant filed his second prior claim for benefits on March 4, 1986. ((Director’s Exhibit (“DX”)2). The claim was denied, on June 6, 1986, because the evidence failed to establish any of the elements of entitlement. (DX 2). No further action was taken on the claim and it is considered closed.

The claimant filed his present claim for benefits on July 22, 2003. (Director’s Exhibit (“DX”)4). On June 16, 2004, the claim was denied by the district director because the evidence failed to establish any of the elements of entitlement. (DX 32). On June 22, 2004, the claimant requested a hearing before an administrative law judge. (DX 33). On August 31, 2004, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers’ Compensation Program (OWCP) for a formal hearing. (DX 38). I was assigned the case on April 14, 2005.

On June 21, 2005, I held a hearing in Pittsburgh, Pennsylvania, at which the claimant and employer, were represented by counsel.¹ No appearance was made, at the hearing, for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant’s exhibits (“CX”) 1-3, Director’s exhibits (“DX”) 1- 38, and Employer’s exhibits (“EX”) 1- 5 were admitted into the record.² Final briefs were initially due October 14, 2005, then extended until December 16, 2005.

Post-hearing evidence consists of CX 4, Dr. Cohen’s deposition, to which there was no objection; Dr. Celko’s deposition, CX 5, to which there was no objection; and, employer’s exhibit 6, Dr. Fino’s deposition, to which there was no objection. (TR 14, 57).

¹ Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(*en banc*), the location of a miner’s last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court’s jurisdiction.

² In an October 27, 2005 letter, the employer withdrew Dr. Fino’s re-readings of X-rays, except films of 4/4/86, 3/5/99, and 10/31/02, in order to comply with evidentiary limitations. (See TR 50-56). On November 18, 2005, the employer substituted a condensed EX 4, showing x-ray reports and SaO2 levels, in place of the original complete set of the Centerville Clinic medical records. I approve the substitution.

ISSUES

- I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?
- II. Whether the miner's pneumoconiosis arose out of his coal mine employment?
- III. Whether the miner is totally disabled?
- IV. Whether the miner's disability is due to pneumoconiosis?
- V. Whether the miner has 47 years of coal mine employment?
- VI. Whether the miner has a dependent?
- VII. Whether there has been a material change in the claimant's condition?
- VIII. Whether there has been a change in an applicable element of entitlement upon which the order denying the prior claim became final?

FINDINGS OF FACT

I. Background

A. Coal Miner

The parties stipulated that the claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 29 years and two months. (Hearing Transcript (TR) 11)(DX 4, 6-9, 21). Any discrepancy between that and the years alleged is not significant for this decision.

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on July 22, 2003. (DX 4). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

The parties stipulated and I find that Consolidation Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001, Part 725 of the Regulations).³

³ 20 C.F.R. § 725.492. The terms "operator" and "responsible operator" are defined in 20 C.F.R. §§ 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis (**disability or death and not pneumoconiosis for claims filed on or**

D. Dependents

The parties stipulated and I find the claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Margaret Bioni. (DX 11). She lives in a personal care home with the claimant's support. (DX 4, 11; TR 16, 27).

E. Personal, Employment and Smoking History⁴

The claimant was born on October 15, 1919. (DX 4). He married Margaret Bioni, on June 26, 1943. (DX 10). Mr. Bioni claims 47 years of mostly underground coal mine employment from 1936 through 1970. (DX 4; TR 28). He was a UMWA member. (TR 28). The Claimant's the last position in the coal mines was that of a coal mine inspector in charge of ventilation, a job he held from 1970-1976. (DX 6, 9; TR 34). He last worked for Consolidation as a foreman, from July 1968 until February 1970; his last coal mine employment. (TR 29). He rarely wore a respirator. From 1976-1985, he reviewed maps and documents as a Bureau of Mines ventilation assistant, going underground infrequently. (TR 35). Mr. Bioni retired in 1985 and has not worked since. (TR 36-37).

The claimant, as part of his foreman duties, was required to walk four to five miles a day, lift and carry 100 pounds five times a day, and crawl. (DX 4; TR 30-31). He retired from the mines in 1985. (DX 4).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. The evidence is conflicting concerning the miner's smoking history. He testified that he smoked for about twenty-four years, about half a pack or so a day. (TR 22-23, 43-44). He began smoking at age seven or eight, but not a half pack per day until he was 21. (TR 44). He never smoked cigars or a pipe and never told anyone he did. (TR 44). He denies telling any doctor he smoked more than 15 years. (TR 45). However, I find he smoked at least 36 pack years, based upon the reports and deposition testimony of the physicians of record, more fully discussed herein.

II. *Medical Evidence*⁵

A. Chest X-rays⁶

after Jan. 19, 2001) arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or after Jan. 19, 2001). To rebut the first, the employer must establish that there were no significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). The second presumption has been rebutted in this case.

⁴ "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

⁵ *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

There were six readings of five X-rays, taken between 4/4/1986 and 5/3/05. All of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b).⁷ None of the readings are positive.⁸ All of the readings are negative, by four physicians, all of whom are either B-readers, Board-certified in radiology, or both.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
CX 1	5/3/05 5/17/05	Cohen	B	1	0/1, q/t	
DX 17	8/7/03 8/8/03	Thomeier	B; BCR	2	Negative	Negative. Cardiomegaly.
DX 18, 19	8/7/03 10/11/03	Navani	B; BCR	2	Negative	Pleuro-parenchymal changes left base. Pacemaker. Cardiomegaly.
EX 2	10/31/02	Fino	B		0/0	
EX 2	3/5/99	Fino	B		0/0	
EX 2	4/4/86	Fino	B		0/0	
DX 2	3/24/86	Yarussi	Unk			Some pleural thickening.
DX 2	12/18/80	Arevalo	BCR		Negative	
DX 1	11/5/80	McMahon	Unk		Negative	

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine subspecialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987), *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993), and *Zeigler Co. v. Kelley*, 112 F.3d 839, 842-

⁶ In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

⁷ ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

⁸ *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. “A “B-reader” is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by “B-readers.” *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993).”

843 (7th Cir. 1997). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category “0,” including subcategories “0/-, 0/0, 0/1,” does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies

Pulmonary Function Studies (“PFS”) are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV₁) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	Age Height	FEV ₁	MVV	FVC	Trac- ings	Compre- hension Cooper- ation	Qualify *Con- form**	Dr.’s Impression
Celko 8/7/03 DX 15	83	1.70		2.59	Yes	Good	No*	Marked DLCO reduction. Effort? (Illegible) Mixed moderate obstructive & restrictive defect. Found acceptable by Dr. Kucera. (DX 16).
	71”	1.67		2.36	Yes	Good	Yes** Yes* Yes**	
Fino 2/14/05 EX 1	85	1.44		2.29	Yes	Good	Yes*	Normal. Combined obstruction and restriction.
	70.5”	1.66*		2.44	Yes	Good	Yes** Yes* Yes**	
Dr.Cohen 5/3/05 CX 1	85	1.83		3.00	Yes	V. Good	No*	Moderately severe obstructive defect. Fino agrees no restriction. (EX 6).
	71”	1.87		2.87	Yes	V. Good	Yes** No* Yes**	

*A “qualifying” pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study “conforms” if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states “(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness...”

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed “unacceptable” when the subject “[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV₁’S of the three acceptable tracings should not exceed 5 percent of the largest FEV₁ or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test.” (Emphasis added).

For a miner of the claimant’s height of 71 inches, § 718.204(b)(2)(i) requires an FEV₁ equal to or less than 1.98 for a male 83 years of age.⁹ If such an FEV₁ is shown, there must be in addition, an FVC equal to or less than 2.55 or an MVV equal to or less than 79; or a ratio equal to or less than 55% when the results of the FEV₁ tests are divided by the results of the FVC test.

C. Arterial Blood Gas Studies¹⁰

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O₂) compared to carbon dioxide (CO₂) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex. #	Physician	PCO ₂	PO ₂	Qualify	Physician Impression
8/6/03 DX 14	Celko	44.0	77.0	No	Unable to do exercise because of CAF+Mitral Valve disease of one year. Fairly close to normal and better than in 1986. (CX 4, p. 69-70).
2/14/05	Fino	43.0	72.0	No	Normal.

⁹ The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are “qualifying.” *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 71” here, the most often reported height.

¹⁰ 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. §718.204(b)(2) permits the use of such studies to establish “total disability.” It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner’s total disability:...

(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part...

EX 2					
5/3/05 CX 1	Cohen	41.6	75.8	No	

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: “Tests shall not be performed during or soon after an acute respiratory or cardiac illness.”

D. Physicians’ Reports¹¹

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner’s respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Ashith Mally has been the miner’s treating physician since 1996. (CX 2). Dr. Mally submitted a three-page report, dated September 13, 2004. Dr. Mally engaged in an internal medicine residency, at Mercy Hospital. He reiterated his 29-year plus history of coal mine employment and his 7.5 to 15 pack year smoking history, ending “many years ago.” Dr. Mally reported Mr. Bioni’s medical history of: mild Cardiomyopathy, obesity, aortic stenosis, COPD, pneumonia, diabetes, and hypertension. He last examined the miner on May 24, 2004. Dr. Mally referred to unidentified “various x-ray reports, which are negative for or read as minimally suspicious for the presence of clinical pneumoconiosis.” (CX 2). He agreed with Dr. Celko’s 8/7/03 PFS and AGS interpretations. Based on Mr. Bioni’s long history of “significant and substantial” coal dust exposure, his examination, PFS showing obstructive and restrictive impairments, and, progression of breathing complaints, Dr. Mally diagnosed both clinical and legal CWP, in spite of negative x-rays. He could not separate the obstructive impairment caused by smoking and coal mine dust exposure, but noted his exposure to coal dust far exceeded his smoking exposure. He concluded the restrictive impairment is consistent with CWP due to coal mine dust exposure. Finally, based on Mr. Bioni’s PFS results, he concluded that the miner’s CWP prevented him from performing his last coal mine job.

Dr. Robert A. Cohen is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary medicine and special competence in critical care. (CX 1). He is presently the Medical Director Pulmonary Physiology and Rehabilitation, Division of Pulmonary Medicine & Occupational Medicine, John H. Stroger, Jr., Hospital of Cook County, Chicago, Ill. Dr. Cohen has reviewed extensive medical literature relating to Black Lung disease and is well-published, including articles on coal mine respiratory diseases, occupational lung diseases, silica

¹¹ *Dempsey v. Sewell Coal Co. & Director, OWCP*, __ B.L.R. __, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

exposure, and Respirable coal dust. He has also made numerous lectures and presentations on the same topics. (CX 1). He is involved in a number of black lung-related projects. (CX 5, pages 5-6). He is a course director for NIOSH spirometry courses. He treats coal miners and runs two occupational lung disease clinics per week. (CX 5). Moreover, he is the medical director for federally-funded black lung clinics throughout the country. (CX 5).

Dr. Cohen's comprehensive report, based upon his examination of and review of listed medical records of the claimant, on May 3, 2005, notes 29-plus years of detailed coal mine employment.¹² Mr. Bioni reported he had not smoked since age 21 and that he had only smoked ten packs between ages 19 and 21. Dr. Cohen noted Dr. Garson's 15 pack year report from 1938-1953, as well as other such reports. (CX 1). Dr. Cohen reported Mr. Bioni informed him that his shortness of breath upon exertion predated the 2003 pacemaker placement and CHF diagnosis. Based lung volumes showing a lack of a restrictive lung disease, Dr. Cohen opined Mr. Bioni's heart disease and obesity cannot be a contributing factor to his FEV1 impairment. He found X-ray evidence borderline negative for interstitial lung disease of CWP.

Dr. Cohen found no history of any other occupational exposure which could cause obstructive lung disease. He reported that obstructive lung disease from coal mine dust can occur in the presence or absence of CWP, and in the presence of negative X-rays. (CX 1, page 12).

Based on arterial blood gases, a pulmonary function study, and a negative chest X-ray, Dr. Cohen diagnosed moderate to severe obstructive lung disease, chronic bronchitis from coal mine dust exposure, and CWP from coal mine dust exposure. (CX 1, page 11; CX 5, pages 24-25).

Dr. Cohen opined that the claimant's pulmonary condition was related and due to his coal dust exposure, precluded Mr. Bioni from engaging in the heavy physical exertion of his last coal mine work. (CX 1 and 5, page 27).

Dr. Cohen testified at a deposition, on October 6, 2005. (CX 5). Dr. Cohen reiterated information from his earlier examination report concerning the miner, including smoking history. He had also reviewed Dr. Fino's report and Dr. Celko's deposition. For deposition purposes he assumed a 36 pack-year history. (CX 5, page 80). Dr. Cohen reiterated Mr. Bioni's medications and medical history, including pacemaker, CAD, mild congestive heart failure, hypertension, pneumonia, diabetes, obesity, prostate cancer, rheumatic fever. He believes Mr. Bioni's obstructive lung disease is due to both his coal mine dust exposure, "predominantly", and contributed to by his smoking. (CX 5, page 17, 22). He admitted the most common cause of COPD in the general population is smoking. (CX 5, page 71). While cessation of smoking does not restore lost lung function, the rate of decline reverts to normal. (CX 5, page 73). Dr. Cohen opined that one can distinguish between the general proportions of impairment caused by coal mine dust exposure and smoking, "which behave very similarly," by reference to epidemiology studies. (CX 5, pages 73-76). He admitted, on cross-examination, that had Mr. Bioni smoked 36 pack-years and never worked in a coal mine, it's a "possibility" that he could have the same degree of COPD with accompanying obstructive lung impairment. (CX 5, page 83).

¹² Dr. Cohen interpreted numerous objective tests and X-rays over many years which exceed the evidentiary limitations and could thus not be considered.

The x-ray he took revealed a normal cardiac silhouette and Cardiomegaly. (CX 5, page 45). All the x-rays reports he reviewed, from 11/5/80 to the present, were negative for CWP. (CX 5, page 47). The PFS revealed a mildly reduced FVC with a moderately severely reduced FEV1 and mildly reduced ratio. He had a mild diffusion impairment and normal AGS for his age. (CX 5, pages 18, 53, 65). The other AGSs he reviewed, from December 1980 through August 6, 2003, showed normal resting results. (CX 5, page 66). The other PFSs he reviewed, from December 1980 through August 17, 2004, showed FEV1/FVC ratios on the low side of normal, an artifact of artificially low FVC, not that he has no obstruction. (CX 5, pages 62-63).

Dr. Cohen testified obesity cannot cause an obstructive impairment and PFS and lung volume studies showed a normal total lung capacity therefore no restriction. (CX 5, pages 23, 43, 58-59). Obstructive impairments do not show up on X-rays. (CX 5, page 23). When heart disease causes a lung function impairment, it causes a restrictive impairment and Mr. Bioni has no restriction. (CX 5, pages 23-4). He admitted Mr. Bioni's cardiovascular problems, a "significant process", could have an effect on lung function. (CX 5, page 39-40). He disagreed with those who believe chronic bronchitis ceases within one year of the last exposure to coal mine dust because it can persist as it does with Mr. Bioni. (CX 5, page 25). Dr. Cohen testified, as in Mr. Bioni's situation, that coal mine dust is retained in the lungs (unlike cigarette-smoking particulates) and the inflammatory process it generates continues because the dust is never expelled; i.e., CWP is progressive. (CX 5, pages 26, 72). He reaffirmed his COPD diagnosis, arising from both coal mine dust exposure and smoking, admitted the x-ray reading did not support the legal criteria for a "clinical" CWP diagnosis, and that Mr. Bioni was totally disabled. (CX 5, page 66-67, 69, 79, 82).

Dr. David A. Celko is board certified in internal medicine and actively treats patients for pulmonary diseases. (CX 4). He is neither Board Certified nor Board Eligible in pulmonary medicine. (CX 4, page 21).

His report, based upon his examination of the claimant, on September 4, 2003, notes 30-plus years of detailed coal mine employment and a 2.5-pack year smoking history, starting at age 19 and ending at age 24. (DX 13). Dr. Celko reported the miner had suffered from pneumonia twice in the past four years

Based on a normal EKG, "non-qualifying" arterial blood gases, a pulmonary function study showing a mixed moderate restrictive-obstructive ventilatory pattern, and a negative chest X-ray showing cardiomegaly, Dr. Celko diagnosed COPD from asthma, occupational and avocational dust exposure, etc., and valvular heart disease. (DX 13; CX 4, pages 73-4). He recommended referral for further evaluation due to chronic asthmatic bronchitis.

He opined the claimant's was totally disabled, from a pulmonary standpoint, from performing his last coal mining job. (DX 13).

Dr. Celko testified at a deposition, on August 11, 2005. (CX 4). He reiterated and elaborated upon the results of his 9/4/2003 examination of the miner. He had previously examined Mr. Bioni at the Department of Labor's request, on 4/4/1986. The April 1986 X-ray was negative for CWP as was the 9/4/03 X-ray, but it did reveal cardiomegaly. (CX 4, page 47-50). His 1986 diagnoses were unrelated to coal dust exposure. (CX 4, page 73). He had also

reviewed Dr. Mally's report. Dr. Celko diagnosed "legal" pneumoconiosis due to the negative X-ray and PFS obstructive changes, although he could not discriminate what was caused by smoking or coal dust exposure. (CX 4, page 13). He found Mr. Bioni disabled from performing his last coal mine employment due to the (legal) pneumoconiosis as a substantial factor. (CX 4, page 14).

Dr. Celko admitted his report had a "differential" diagnosis which was not all-inclusive, that is, it referred to "a list of potential possibilities that could cause a problem to occur." (CX 4, page 74-6). In other words, a number of (non-occupational) factors, i.e., smoking, could have caused Mr. Bioni's chronic asthmatic bronchitis. (CX 4, page 76, 83). Dr. Celko had not ruled out causes other than coal dust as the cause of Mr. Bioni's asthmatic bronchitis, but believes the cause was coal dust exposure. (CX 4, pages 77, 82). Moreover, he admitted he could not determine the contribution of coal dust exposure vis a vie other causes, that is, "which was the most contributing factor." (CX 4, page 78-80). Nor could he ascertain the relative contribution of Mr. Bioni's cardiac versus pulmonary problems (without a further work-up), but "lean(s) more toward the pulmonary cause of his symptoms." (CX 4, page 80-81).

According to Dr. Celko, Mr. Bioni's PFS showed significantly reduced FEV1 and FVC. (CX 4, page 15). Moreover, his diffusing capacity was diminished and lung volumes abnormal. (CX 4, page 16). Since 1986, the miner's PFS results had deteriorated. (CX 4, page 17). Dr. Celko admitted that as an individual ages, one's pulmonary capacity decreases and the PFS "predicted normals" decrease. (CX 4, pp. 54-55). According to Dr. Celko, as a general theme "reversibility" on a PFS, post-bronchodilation, indicated the defect is not attributable to coal dust exposure, except with COPD with asthma where there can be some improvement. (CX 4, page 56). Mr. Bioni's post-bronchodilation PFS demonstrated dramatic improvement. (CX 4, page 58). Moreover, he admitted the PFS abnormalities, i.e., the obstructive component, could be consistent with a 16.5 pack year smoking habit. (CX 4, page 57-58, 63). Overt CHF could certainly cause a restrictive component on PFS. (CX 4, page 63). Dr. Celko testified one's questionable effort and possibly obesity, as here, could affect the "restrictive" defect finding. (CX 4, page 61-62). The lung volume testing, the "gold-standard" for determining restriction, however, showed a restrictive defect. (CX 4, page 63).

Dr. Celko testified Mr. Bioni's diffusion capacity testing, on 9/4/2003, revealed a markedly reduced DLCO. (CX 4, pages 64-65). On cross-examination, he admitted both smoking and heart disease can produce such results. (CX 4, pages 64-65). Mr. Bioni's pulse oximetry, on 9/4/2003, was normal. (CX 4, page 65).

Dr. Celko did not agree with Dr. Fino's opinion attributing Mr. Bioni's impairment to heart problems because cardiac disease does not cause obstructive defects and if Mr. Bioni's impairment was of cardiac origin, he would have seen more congestive heart failure or a restrictive disease. (CX 4, pp. 17-18). Nor did the X-ray readings he saw reflect CHF. Both coal mine employment and smoking can cause obstructive changes, particularly centrilobular emphysema. (CX 4, page 18-19). However, there is no testing he is aware of that can discriminate between the two. (CX 4, page 19). Rather, one must examine the occupational exposure, intensity, and time frames, as he did in this case. (CX 4, page 20). He admitted, on cross-examination, that Mr. Bioni's complaints and symptoms were just as consistent with bronchitis due to smoking as they are to legal or clinical pneumoconiosis. (CX 4, page 39).

Dr. Warfield Garson was an A-reader and Board-certified in preventive medicine with a subspecialty in pulmonary medicine. Between November 28, 1998 and April 11, 2000, he examined the miner five times. His consultation report, based upon his previous examinations of (review of the medical records of) the claimant, the last time on April 11, 2000, notes about 33 years of coal mine employment and a 7.5 to 15 pack-year smoking history (which began in 1938 and ended in 1953). (DX 20).

Based on his examinations, the miner's history, an essentially normal EKG, arterial blood gases, a pulmonary function studies indicating early airway obstruction with a mild restrictive defect, and a ("0/1") chest X-ray showing mild pulmonary interstitial changes, Dr. Garson diagnosed "legal" pneumoconiosis from coal mine employment; COPD significantly related to his coal mine dust exposure. Dr. Garson concluded the miner was totally disabled due to his pulmonary problems, as well as other physical problems. Mr. Bioni's COPD is a substantial contributing factor. (DX 20).

Dr. Garson opined that the claimant's pulmonary condition was related to his coal dust exposure rather than his "relatively small smoking history which would hardly seem sufficient to account for his pulmonary problems. . . (which got) progressively worse even after he had stopped smoking cigarettes." (DX 20).

Dr. Gregory Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, examined the miner on February 14, 2005. He reviewed enumerated medical records on behalf of the employer and submitted his opinions in reports, dated May 1, 2005 (EX 1) and June 1, 2005 (EX 2). His report notes 34 years of underground coal mine employment and that Mr. Bioni reported that he "never really smoked cigarettes as a habit." (EX 1, EX 6, page 11). Dr. Fino reviewed the miner's medical and family histories as well as his symptoms.

Dr. Fino had a digital X-ray taken, but the results exceed admissible limits. I only consider his review of X-rays dated 4/4/86, 3/5/99, and 10/31/02, which were negative for CWP but showed a progressive increase in the size of the heart. He found lung volumes consistent with a combined obstruction and restriction. The diffusing capacity was essentially normal although the test was invalid. Oxygen saturation was normal. Carboxyhemoglobin results were normal. The AGS results were normal. Dr. Fino prepared a table showing the many varied cigarette smoking histories provided by the claimant to physicians. (EX 1). The reports ranged from "never smoked" to a pack per day for 36 years. Dr. Fino reported Mr. Bioni had no pulmonary impairment when he left the mines, but the miner's lung function studies began to show some reductions around 1999-2000 when his X-rays showed changes consistent with "significant heart disease." (EX 1, page 16). Dr. Fino concluded that the claimant did not have any coal dust related lung condition, but rather that Mr. Bioni's heart problems have resulted in significant abnormality on PFS; that is he disabled due to significant cardiac disease. (EX 1, page 16).

For his supplemental report, Dr. Fino reviewed Dr. Cohen's 5/12/05 report. And reiterated his earlier report (EX 2). Although he agreed that literature has shown coal mine dust inhalation can cause an obstructive ventilatory abnormality, he disagreed with Dr. Cohen, and believes Mr. Bioni has no coal mine dust related pulmonary condition. (EX 2).

Dr. Fino testified at a deposition, on November 9, 2005. (EX 6). He reviewed his credentials and reiterated his earlier findings and conclusions. Additionally, he had read Dr. Celko's 8/11/2005 deposition. Dr. Fino opined that Mr. Bioni was obese, but found no abnormalities in the examination. He found the miner had a "markedly" enlarged heart, i.e., pleural effusion, which means his heart does not function well. That is not due to coal mine dust. X-rays of 4/4/86, 3/5/99 and 10/31/02 revealed the onset of Cardiomegaly in 2002. He opined Mr. Bioni did not have any clinically significant impairing lung function abnormality until around 2000. (EX 6, page 23). The Single Breath Diffusing Capacity test revealed normal results. (EX 6, page 29). The loss of FEV1 is consistent with aging. (EX 6, page 36).

According to Dr. Fino, Mr. Bioni's obstruction (agreeing it is not due to heart disease), which by itself would not be disabling, could represent an asthma-type condition, but nothing due to coal dust.¹³ (EX 6, pages 31, 33, 49, 54). His FVC and FEV1 restrictive-like reductions are from the enlarged heart, overweight, and consistent with an asthma condition. (EX 6, page 66). Dr. Fino explained he ruled out coal dust related restriction because Mr. Bioni did not exhibit significant pulmonary fibrosis, which is the only way it can cause restriction. (EX 6, page 64). He had no evidence of impairment or disability related to clinical or legal CWP. Dr. Fino opined that Mr. Bioni's smoking does not cause any pulmonary impairment. (EX 6, page 63). On cross-examination, he explained how he extrapolated PFS norms following Crapo and Morris' text. (EX 6, page 38-42). Dr. Fino admitted that Mr. Bioni had a significant respiratory impairment causing a (total) disability. (EX 6, page 41-42). He testified that he diagnosed a "reversible airway obstruction." (EX 6, page 66).

III. Hospital Records & Physician Office Notes

During the course of medical treatment, Mr. Bioni underwent many pulmonary function studies and arterial blood gas studies. (CX 3-Centerville Clinic records). None of the PFS had "qualifying" values. The following PFS had non-qualifying values: 8/12/02; 10/5/01; 3/17/00; 3/5/99; 3/25/98; 2/21/97; 4/19/96; 3/2/94; 1/20/93; 1/30/92; 1/23/91; 6/19/90; 8/30/88. (CX 3). The following AGS had non-qualifying values: 2/21/94; 1/20/93; 1/15/92; 1/23/91; 6/16/90; 8/30/88. (CX 3).

The Centerville Clinic records submitted by the claimant contain a 11/28/88 pulmonary evaluation for cough and shortness of breath by Dr. Warfield Garson. (CX 3). Dr. Garson reported the miner's childhood asthma, his lengthy coal mine employment and a 15 pack-year smoking history from 1938-1953. Dr. Garson diagnosed COPD and found a clear indication of early airway obstruction with a mild restrictive defect. The miner's heart was normal and an x-ray showed mild pulmonary interstitial changes. Dr. Garson stated, "I would consider that this man is permanently and totally disabled from work where he would be exposed to underground coal dust as it would be imprudent to extend further this man's early lung findings by such further hazardous exposure." (CX 3).

A June 1990 examination report, by Dr. Kimberle Vore, listed a diagnosis of stable COPD "with a component of pneumoconiosis" based on a 0/1 x-ray and PFS showing mild

¹³ Dr. Fino defined "obstruction" as a reduction in the ratio of FEV1 to FVC. "Restriction" is "a reduction in the FVC and potentially a reduction in lung volumes, when the reduction is due to scarring or fibrosis." (EX 6, pages 52, 55). One must then look at the FEV1 alone to determine the degree of obstruction, according to Dr. Fino.

restrictive defect and early airway obstructive defect. (CX 3). The Centerville Clinic records submitted by the claimant contain a February 1992 examination report by Dr. Nicholas Tsambassis to evaluate his abnormal glucose tolerance test. (CX 3). An EKG showed first degree AV block. Examination revealed some scattered rales and obesity. Dr. Tsambassis' impression included CWP, but appears based on the miner's reported history. (CX 3). These Centerville Clinic physicians, including Dr. Garson, Dr. Ginart and Dr. Kroh, continued to list CWP and COPD as diagnoses for many years, primarily based on PFS with mixed results and examination results with repeated "0/1" x-ray readings.

The Centerville Clinic records submitted by the employer (EX 4) show: a "0/1" X-ray readings in 8/02; in 10/01; 3/00; in 3/99; in 3/98; 2/97; 4/96; 2/94; 1/93; 1/92; 1/91; 1/90; 1/88; the majority showing mild interstitial changes and, two readings, in 5/95 and 8/88, showing mild interstitial changes with no pleural changes. (EX 4). The Centerville Clinic records also reflect Oximetry test results of 8/12/02 (within normal range); 3/17/00 (within normal range); 3/5/99 (within normal range); and, 3/25/98 (within normal range). The records reflect Oximetry tests of 2/21/97 and 4/19/96. (EX 4).

The employer submitted treatment and evaluation records from Lungs at Work for 2003 through 2005, which include various test results, patient visit flowsheets, and Dr. Celko's 9/4/03 examination report. (EX 5). Those records reveal a series of X-ray readings negative for clinical CWP or occupational lung disease, and some showing normal cardiac silhouettes with others showing an enlarged heart and mild basilar fibrotic changes. Those records also contain an 8/17/05 PFS showing moderate restrictive ventilatory pattern, restrictive lung volumes, with marked DLCO reduction, and uninterpreted PFS of 8/7/03. Uninterpreted EKG, AGS and various oximetry test results are contained in the record. A 7/9/03 PFS, was found by Dr. Celko, to show mixed moderate restriction with marked DLCO reduction. A 2/8/01 PFS was interpreted by Dr. Celko as showing a mild restrictive/obstructive ventilatory pattern. In a 1986 physical examination, Dr. Celko included a medical assessment of Mr. Bioni's daily physical limitations due to pulmonary disease, i.e., walking slowly over a quarter mile or more, climbing 12 steps, lifting 30 pounds, and carrying 30 pounds 50 feet. (EX 5). Dr. Celko diagnosed a very mild obstructive ventilatory impairment, at that time. (EX 5).

IV. Witness' Testimony

Eight-five year old Mr. Bioni testified about his primarily underground coal mine employment, which involved heavy labor and began in 1937. (TR 17-21). For the past ten years and presently, he gets "winded" upon "any exertion at all whatsoever . . . weak and I got to stop, no matter what I'm doing." (TR 22, 38). He awakens nights with a cough. (TR 23, 38). His breathing problems have worsened since 1986. Dr. Mally, his treating physician of fifteen years whom he sees about every three months for a full examination, treats his breathing and has prescribed Serevent for his breathing. (TR 24, 46). Previously he treated with physicians at the Centerville Clinic. (TR 40). Mr. Bioni has hypertension, diabetes, congestive heart failure, heart palpitations, and chest pain on exertion. (TR 41). He had rheumatic fever as a teen and a heart murmur. He got a pacemaker, in 2003, which has resolved his heart problems, and has been hospitalized twice with pneumonia. (TR 25). He was never informed he had asthma, bronchitis, or allergies. (TR 42). He could not return to the strenuous work in the mines because he would

not have the ability to do so, he would get winded and he would cough a lot in the dust. (TR 25, 45-46).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). [See *Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997)]. [See *Adams v. Director, OWCP*, 886 F.2d 818, 820 (6th Cir. 1989).] The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. See *Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, “[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden.” *Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501, No. 01-4064 (6th Cir. July 31, 2003), citing *Greenwich Collieries [Ondecko]*, 512 U.S. 267 at 281; see also *Peabody Coal Co. v. Odom*, ___ F.3d ___, 2003 WL 21998333 (6th Cir. Aug. 25, 2003)(Credit treating physician on more than mere status).

Since this is the claimant’s third claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.¹⁴ Although the new regulations

¹⁴ Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Sections 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner’s physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner’s physical condition at the time of his death.

dispense with the “material change in conditions” language of the older regulations, the criteria remain similar to the “one-element” standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), which was adopted by the United States Court of Appeals for the Fourth Circuit, in *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev’g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). In *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004), the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless the administrative law judge finds that “one of the applicable conditions of entitlement. . . has changed since the date upon which the order denying the prior claim became final.” 20 C.F.R. Section 725.309(d); *White v. New White Coal Co., Inc.*, 23 B.L.R. 1-1, 1-3 (2004). According to the Board, the “applicable conditions of entitlement” are “those conditions upon which the prior denial was based.” 20 C.F.R. Section 725.309(d)(2).

To assess whether a material change in conditions is established, the Administrative Law Judge (“Administrative Law Judge”) must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial, e.g., disability due to the disease.¹⁵ *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev’g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). See *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. See *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.*), the Benefits Review Board held the “material change” standard of section 725.309 “requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred.” Unless an element has previously been adjudicated against a claimant, “new evidence cannot establish that a miner’s condition has changed with respect to that element.” Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability “may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions...”

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party’s failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

¹⁵ *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner’s worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition, under 20 C.F.R. § 725.309, absent corroborating medical evidence.

The claimant's prior application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

In this case, there is no question that there has been a material change in condition, as discussed more fully below. All the doctors agree the miner suffers from an obstructive lung defect and a total respiratory disability. Additionally, I have found he has established "legal" pneumoconiosis, although that finding is unnecessary to find a material change in condition.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."¹⁶ 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.¹⁷

¹⁶ Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co.*, 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act. In *Workman v. Eastern Associated Coal Corp.*, 23 B.L.R. 1-22, BRB No. 02-0727 BLA (Aug. 19, 2004)(order on recon)(*En banc*) the Board ruled that because the potential for progressivity and latency is inherent in every case, a miner who proves the presence of pneumoconiosis that was not manifest at the cessation of his coal mine employment, or who proves that his pneumoconiosis is currently disabling when it was previously not, has demonstrated that the disease from which he suffers is of a progressive nature. In amending section 718.201, DOL concluded chronic dust diseases of the lung and its sequelae arising out of coal mine employment "may be latent and progressive, albeit in a minority of cases." See 64 Fed. Reg. 54978-79 (Oct. 8, 1999); 65 Fed. Reg. 79937-44, 79968-72 (Dec. 20, 2000); 68 Fed. Reg. 69930-31 (Dec. 15, 2003). "Although every case of pneumoconiosis does not possess these characteristics, the regulation was designed to prevent operators from asserting that pneumoconiosis is never latent and progressive. 20 C.F.R. Section 718.201(c); see *National Mining Association, et al. v. Chao, Sec. of Labor*, 160 F. Supp. 2d 47 (D.D.C. Aug. 9, 2001) *aff'd*, 292 F.3d 849 (D.C. Cir. 2002)("*NMA*"), 292 F.3d at 863." *Midland Coal Co. v. Director, OWCP[Shores]*, 358 F.3d 486 (7th Cir. 2004). Seventh Circuit upheld DOL's 2001 definition of CWP as a latent and progressive disease. DOL's regulation, on this scientific finding is entitled to deference. It is designed to prevent operators from claiming CWP is never latent and progressive.

¹⁷ Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers'

The term “arising out of coal mine employment” is defined as including “any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” Thus, “pneumoconiosis”, as defined by the Act, has a much broader legal meaning than does the medical definition.

“...[T]his broad definition ‘effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.’” *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing*, *Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for “complicated pneumoconiosis” found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.¹⁸ 20 C.F.R. § 718.202(a)(4).

The Third Circuit has held that the four methods of establishing the existence of the disease, provided in 20 C.F.R. § 718.202, are not to be considered in the disjunctive; that is, relevant evidence developed under the four methods of proof are to be considered together to determine whether a claimant has pneumoconiosis. *Penn Allegheny Coal Co. v. Williams &*

pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

¹⁸ In accordance with the Board’s guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing* *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are “documented” (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and “reasoned” since the documentation supports the doctor’s assessment of the miner’s health.

Director, OWCP, 114 F.3d 22 (3rd Cir. June 3, 1997) *Citing* 30 U.S.C. § 923(b) and *Kertesz v. Crescent Hills Coal Co.*, 788 F.2d 158 (3d Cir. 1986).

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. *Id.*; *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)." (Emphasis added). A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The X-rays in this matter are negative for pneumoconiosis. However, they do show degrees of developing interstitial fibrosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.¹⁹ *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Dr. Cohen as the most qualified, followed by Drs. Fino and Garson. Dr. Celko's qualifications are not of the degree of the former, but superior to Dr. Mally's.

¹⁹ *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984)..." In *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4). (It also rejected Dr. Fino's opinion that the miner's affliction was due solely to smoking and not coal dust exposure because the PFS were not consistent with fibrosis, as would be expected in simple CWP. Fibrosis, while an element of medical CWP, is not a required element of legal CWP).

While the courts and the Board earlier recognized that there may be a practical distinction between a physician who merely examines a miner and one who is one of his “treating” physicians, that preference has largely been obviated, except in the Third Circuit.²⁰ In *Black and Decker Disability Plan v. Nord*, Case No. 02-469, ___ U.S. ___, ___ S.Ct. ___ (May 27, 2003), the Court held ERISA plan administrators (Courts) need not give special deference to the opinion of a treating physician. Dr. Mally was Mr. Bioni’s treating physician for at least five years. As such, his opinion must be considered under the criteria of section 718.104(d).²¹ Dr. Fino pointed

²⁰ “Treatment” means “the management and care of a patient for the purpose of combating disease or disorder.” DORLAND’S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). “Examination” means “inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination.” DORLAND’S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994). *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for Judge to accord greater weight to treating physician over non-examining doctors). In *Soubik v. Director, OWCP*, ___ F.3d ___, Case No. 03-1668, 23 B.L.R. 2-85 (3rd Cir. April 30, 2004), citing *Mancia v. Director OWCP*, 130 F.3d 579, 590-591 (3rd Cir. 1997), the Court reiterated that “It is well-established in this Circuit that treating physician’s opinions are assumed to be more valuable than those of non-treating physicians. *Lango v. Director, OWCP*, 104 F.3d 573 (3rd Cir. 1997). The Court wrote that while there is “some question about the extent of reliance to be given a treating physician’s opinion when there is conflicting evidence, *compare Brown v. Rock Creek Mining Co.*, 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating physicians are clearly entitled to greater weight than those of non-treating physicians), “a judge may require “the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner’s death).” *But see, Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge’s crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The Court called judge’s deference to the “treating physician” over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.3d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989). *Consolidation Coal Co. v. Director, OWCP [Held]*, ___ F.3d ___, Case No. 99-2507 (4th Cir. Dec. 20, 2000)(with Dissent). Improper to accord greater weight to the opinion of treating physician because he had treated and examined claimant each year over the past ten years. In *Grizzle v. Pickland Mather & Co.*, 994 F.2d 1093 (4th Cir. 1993), we clearly stated we had not fashioned any presumption or requirement that the treating physicians’ opinions be given greater weight. While the treating physician’s opinion here may have been entitled to “special consideration”, it was not entitled to the greater weight accorded. In *Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501, No. 01-4064 (6th Cir. July 31, 2003), the Court made clear its view that no deference is given to treating physicians merely because of their status as the same. It pointed out, citing *Black & Decker Disability Plan v. Nord*, 123 S.Ct. at 1969, 1971, the Supreme Court itself has “disapproved of the ‘treating physician rule’ with language that criticizes the principle itself, rather than its operation in an ERISA context.”

²¹ § 718.104(d) Treating Physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner’s treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

out how important it is to have a complete view of a miner's medical history to make an accurate diagnosis. Moreover, the records from Lungs at Work reflect that Dr. Celko had objective tests routinely performed in addition to regular pulmonary examinations. Dr. Garson also treated the miner over a period of two years during which he examined the miner five times. He is Board-certified in primary care medicine. Thus, while I do not give complete deference to these doctors based on their status, I give their opinions somewhat greater weight, except as otherwise noted, than I would otherwise afford the same absent such relationship.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).²² This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Dr. Garson's 4/11/00 report is five years old. He did not have the benefit of reviewing the more recent evidence. Thus, in spite of his qualifications, I give his conclusions less weight due to their lack of recency.

Dr. Fino's opinion, that since Mr. Bioni did not exhibit "significant pulmonary fibrosis" he could rule out coal mine dust exposure as a cause of his obstructive impairment, which is the only way it can cause restriction, is of concern. In *Underwood v. Elkay Mining Inc.*, 105 F.3d 946, 951 (4th Cir. 1997), the Court stated that "[A]n ALJ must not rely upon the opinion of an expert who expresses an opinion based on a premise 'antithetical to the Black Lung Benefits Act' because such an opinion 'is not probative.'" *Thorn v. Itmann Coal Co.*, 3 F.3d 713, 719 (4th Cir. 1993). The Court listed opinions addressing "hostility to the Act."

A similar opinion by Dr. Fino, among other matters, resulted in the Fourth Circuit's affirmance of a judge's decision to afford Dr. Fino's opinion less weight. *Cf. Consolidation Coal Co. v. Director, OWCP [Wasson]*, Case No. 98-1533 (4th Cir., Nov. 13, 2001)(Unpublished). Moreover, as in *[Wasson]*, there are problems with the DLCO

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication office shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officers' decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

²² *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En Banc.*). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *See also Abshire v. D & L Coal Co.* 22 B.L.R. 1-203 (2002), citing *Staton v. Norfolk & Western Railroad Co.*, 65 F.3d 55, 19 B.L.R. 2-271 (6th Cir. 1995); *Woodward v. Director, OWCP*, 991 F.2d 314, 17 B.L.R. 2-77 (6th Cir. 1993); *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990); and, *Clark v. Karst-Robbin Coal Co.*, 12 B.L.R. 10-149 (1989), the Board holds greater weight may be accorded to more recent X-ray evidence of record. In *Abshire*, the Board also recognized *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 11 B.L.R. 2-1 (1987) (CWP is a progressive disease).

tests of Drs. Fino and Celko in this case, as discussed below. I am mindful of the proscription against “playing doctor”, but use the DLCO discussion not for diagnosis, but rather to determine the value of the doctors’ opinions.

The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition (2001), Chapter 5, Paragraph 5-4e, discusses DLCO testing and the use of Tables 5-6a for reference values for population-based predicted normal diffusing capacity and Table 5-12 for classification of respiratory impairment based on DLCO testing. A cursory look at Table 5-6a shows that the “predicted normal” used by both doctors, in developing their opinions, was incorrect. Dr. Celko used a “predicted normal” of 33.68. That figure is applicable to 74 year old male who is 180 cm tall. Mr. Bioni was 83 years old. Thus, a more accurate “predicted normal” was closer to “27.1.” Thus, rather than being 56% of predicted normal as he reported, the result was closer to 69%. That is a result suggesting greater support for the result he reported, of “markedly reduced”. Dr. Celko admitted that such results can be from smoking and heart disease.

On the other hand, Dr. Fino reported an incorrect height of 79 inches (179 cm) which slightly skewed the results. Dr. Fino used a “predicted normal” of 29.54. Use of the more accurate height “predicted normal” would have shown the result to be closer to 58% suggesting a greater impairment, an abnormal result, rather than the “normal” result he reported. Thus, I give Dr. Fino’s opinion concerning the non-coal dust etiology of the miner’s respiratory impairment lesser weight.

While none of the reviewing physicians, except Dr. Mally and initially Dr. Cohen, diagnosed “clinical” CWP, all the reporting physicians agree that Mr. Bioni suffers from an obstructive defect.²³ It was generally agreed that heart disease does not cause obstructive impairments. All (Drs. Cohen, Celko, Mally, Garson) except Dr. Fino agree Mr. Bioni has COPD. All (Drs. Fino, Celko, Mally, Garson) except Dr. Cohen agree Mr. Bioni has a “restrictive” ventilatory defect. Only Dr. Fino attributed the “restrictive” ventilatory defect to obesity, an enlarged heart, and asthma. Dr. Mally admitted he could not distinguish between obstructive defects due to smoking and due to coal mine dust exposure. In spite of his role as treating physician, given that Dr. Mally is the least qualified physician, submitted a 3-page report, did not make a comprehensive review of the medical records and tests and has no special expertise diagnosing CWP, I credit the opinions of the remaining doctors on the absence of “clinical” CWP (particularly given the negative x-ray history) and not Dr. Mally’s “clinical” CWP diagnosis. Nor do I credit Dr. Cohen’s clinical CWP diagnosis which was initially based on his assumption that Mr. Bioni had no other significant exposure that could cause COPD, particularly given the negative x-ray history and the miner’s greater smoking history.

Dr. Celko’s initial report was undermined during cross-examination at his deposition. There, he admitted it was what he called a “differential” diagnosis. He explained that meant that it was not “all-inclusive” and referred to “a list of potential possibilities that could cause a problem to occur.” So, as he put it, smoking could have

²³ The treatment records often referred to pneumoconiosis, but were not supported by any positive X-rays nor were such references well-reasoned.

caused Mr. Bioni's asthmatic bronchitis. Nor, without a further cardiac work-up could he ascertain the relative contribution of Mr. Bioni's heart versus pulmonary problems. No such cardiac work-up was ever provided to Dr. Celko. Moreover, Dr. Celko admitted "reversibility" on PFS indicates a pulmonary impairment is not from coal dust exposure, except for "some improvement" with COPD with asthma. Yet, Mr. Bioni's PFS showed "significant" reversibility. Finally, He admitted a reduced DLCO result (as he found here) can be from smoking and heart disease.

Dr. Cohen was the only doctor whose (lung volume) testing showed no "restrictive" ventilatory defect. He relied on the absence of such a "restrictive" ventilatory defect to rule out heart disease as the cause of Mr. Bioni's respiratory symptoms. Yet, he alone diagnosed mild CHF. Dr. Celko excluded CHF based on x-ray results. Both he and Dr. Fino diagnosed cardiomegaly, i.e., an enlarged heart. Dr. Mally alone listed cardiomyopathy as a diagnosis. Dr. Celko alone listed valvular heart disease as a diagnosis. Dr. Celko pointed out that heart disease does not cause obstructive impairments and that "overt" CHF (Dr. Cohen found mild CHF) can cause a restrictive impairment. Dr. Celko disagreed with Dr. Fino's attribution of the impairment to heart disease, but did not provide a rationale for why the restrictive impairment he (Celko) diagnosed was not consistent with Dr. Fino's opinion. There can be little dispute that Mr. Bioni suffered from heart disease.²⁴ Mr. Bioni has a pacemaker.

Dr. Fino alone found the miner's smoking causes no pulmonary impairment, although he knew it was likely higher than the miner had reported to him. Drs. Mally, Celko and Cohen all attributed a portion of the miner's COPD to smoking, although, with the exception of Dr. Cohen (who found coal mine dust exposure the "predominant" factor), could not ascertain the portion. Both Dr. Fino and Dr. Celko found "reversibility" on PFS which indicated a non-"clinical CWP" etiology for the restrictive impairment.

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking. However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather must prove by a preponderance of the evidence that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (CA4 1990). (Affirms BRB's decision, in *Scott v. Mason Coal Co.*, No. 88-1838 BLA (BRB June 22, 1990)). *Robinson* discusses the views of the Third, Sixth, Seventh, Tenth, and Eleventh Circuits and concludes, "the standards expressed are practically the same in essence and effect." *Robinson*, at 2-76. [However] "[I]f the claimant would have been disabled to the same degree and by the same time in his life if he had never been a miner, then benefits should not be awarded." *Robinson*, at 2-77. Nor need the physicians apportion what part is due

²⁴ "Cardiomegaly" is a morbid condition characterized by enlargement of the heart... DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 25th Edition (1974), p. 263-4. CHF is congestive heart failure, the failure of the heart to maintain an adequate output resulting in diminished flow to tissues and congestion of pulmonary or systemic circulation. *Id* at 299. Cardiomyopathy is "a general diagnostic term designating primary myocardial disease, often of obscure or unknown etiology." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 25th Edition (1974), p. 264. Myocardial disease pertains to the muscular tissue of the heart. *Id.* at 1009.

to cigarettes versus coal mine dust exposure.

Given the little weight I give Dr. Fino's opinion (a lack of coal dust etiology) and the fact Drs. Mally, Cohen, Celko, and Garson all attributed a part of the miner's obstructive respiratory impairment to his smoking, I find it was caused at least in part by his cigarette smoking. Nor did Dr. Fino reconcile Dr. Celko's abnormal DLCO results or the findings by Drs. Celko and Cohen of diffusion impairment.

Given that Dr. Cohen's finding of a lack of a restrictive impairment is somewhat of an anomaly, considering that both Drs. Fino and Celko earlier found such an impairment and the treatment records reflect the same, and he placed great weight upon that in ruling out heart disease as an etiology of the respiratory impairment, I give somewhat less weight to his opinion that heart disease is not the cause of the (restrictive) respiratory impairment.²⁵

In conclusion, there are discrepancies and flaws in each of the reporting physicians' opinions which I have pointed out. While not accepting Dr. Fino's ruling out of a coal dust etiology for the obstructive impairment, I find his comprehensive analysis linking the (restrictive) respiratory impairment of the miner's heart disease compelling. Dr. Celko's opinion regarding the impact of heart disease is of little or no assistance; he required and did not get a further cardiac work-up. Dr. Cohen's initial report had a grossly understated smoking history and, despite being told to assume a 36-pack year smoking history at his deposition, he continued to support his initial opinion. Dr. Mally's three-page report is inadequate, as discussed above. Dr. Garson last examined the miner, in 2000, somewhat before or at the earliest stages of his heart disease. So, his opinions concerning etiology of the impairment merits lesser weight. So, while it is established that the heart disease is the cause of the restrictive impairment (found by all but Dr. Cohen), and not the obstructive impairment, the remaining causes of the obstructive impairment are the issue. Is the obstructive impairment caused by smoking, coal mine dust exposure, or asthma, and to what degree?

I give little credit to Dr. Fino's opinion that the miner's impairment is not due to smoking. In spite of a smoking history higher than Mr. Bioni reported to Dr. Fino, the latter persisted in referring to it as minimal. However, both he and Dr. Celko interpreted the miner's PFS as showing "reversibility" which indicates a non-coal mine dust etiology of the obstructive impairment. In fact, Dr. Celko found "dramatic" reversibility. When most of the reporting doctors reported it is not possible to apportion the influence of smoking versus coal dust on the obstructive impairment, Dr. Cohen did. I accept the majority view regarding apportionment.²⁶ Moreover, Dr. Cohen's opinion may be tainted by the anomalous "no restrictive impairment" results of his PFS. Dr. Garson did not adequately explain why the miner's 36 pack-year smoking history did not cause a portion of Mr. Bioni's obstructive impairment. In fact, he had an under-reported smoking history and was not as fully informed about the miner's heart disease. Dr. Mally could not separate the relative contribution of smoking versus coal dust in his etiology

²⁵ I note Dr. Fino's testimony that he would have interpreted Dr. Celko's tests as the latter did.

²⁶ There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) citing generally, *Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).

diagnosis. Thus, I conclude, particularly given the “reversibility” of the PFS results, discussed above, that the evidence establishes that the miner’s obstructive impairment is caused by his cigarette smoking history and possibly asthma, rather than obesity or coal mine dust exposure and that coal mine dust did not substantially aggravate and was not significantly related to Mr. Bioni’s impairment.

I find the claimant has not met his burden of proof in establishing the existence of “legal” pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff’g sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation’s coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).²⁷ Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner’s respiratory or pulmonary condition prevents him from engaging in his usual coal

²⁷ The Board has held it is the claimant’s burden to establish total disability due to CWP by a preponderance of the evidence. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986)(en banc). 20 C.F.R. § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:

(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner’s pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

mine employment and gainful employment requiring comparable abilities and skills; and lay testimony.²⁸ Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains “contrary probative evidence.” If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine “whether it outweighs the evidence supportive of a finding of total respiratory disability.” *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff’d on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor’s claim or deceased miners’ claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). As noted above, Dr. Fino’s 2005 PFS had qualifying values, both pre-bronchodilation and post-bronchodilation. Dr. Cohen’s 2005 PFS was non-qualifying. Dr. Celko’s 2003 PFS had a non-qualifying pre-bronchodilation result and a qualifying post-bronchodilation result. These mixed results are insufficient standing alone to establish total disability. However, when considered with the fact all the reviewing physicians have found the miner totally disabled, it is established the miner is totally disabled.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b) (2)(ii). The AGSs are all non-qualifying and thus are insufficient standing alone to establish total disability.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner’s respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, “...all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element.” *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant’s usual coal mine employment with a physician’s assessment of the claimant’s respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

²⁸ In a living miner’s claim, lay testimony “is not sufficient, in and of itself, to establish disability.” *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner’s statements or testimony insufficient alone to establish total disability).

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms render him unable to engage in any physical exertion, I find he is incapable of performing his prior coal mine employment.

Given that all the physicians believe the miner suffers a total respiratory disability, but merely differ as to the cause of the disability, I find the Claimant has established total disability.

I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability

The revised regulations, 20 C.F.R. § 718.204(c)(1)²⁹, require a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability.³⁰ The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).³¹

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to

²⁹ *Gross v. Dominion Coal Corp.*, 23 B.L.R. 1-8, BRB No. 03-0118 (2003). "The substantially contributing cause' standard of revised Section 718.204(c) was not intended to alter the meaning of 'total disability due to pneumoconiosis' as previously determined in decisions by the various United States Courts of Appeal under Part 718, but rather was intended to codify the courts' decisions. 65 Fed. Reg. at 79946-47.

³⁰ This standard is more consistent with the Third Circuit's pre-amendment "substantial contributor" standard set forth in *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 B.L.R. 2-23 (3d Cir. 1989) than the Fourth Circuit's "contributing cause" standard set forth in *Robinson v. Picklands Mather & Co./Leslie Coal Co. v. Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35, 38 (4th Cir. 1990). In *Gross v. Dominion Coal Corp.*, 23 B.L.R. 1-8, BRB No. 03-0118 (2003), the Board observed that "[U]nder the existing law of the Fourth Circuit, claimant is not required to establish relative degrees of causal contribution by pneumoconiosis and smoking to demonstrate that his total disability is due to pneumoconiosis. See *Robinson v. Picklands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (CA4 1990) (holding that a claimant must prove that pneumoconiosis is at least a contributing cause of total disability). Pneumoconiosis must be a necessary condition of the claimant's disability in that it cannot play a merely *de minimis* role. *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1196 n.8, 19 B.L.R. 2-304, 2-320 n.8 (4th Cir. 1995)."

³¹ Effective January 19, 2001, § 718.204(a) states, in pertinent part:

For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

qualify for benefits.” *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff’d* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.* (So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability). The fact that a physician does not explain how he or she could distinguish between disability due to coal mining and cigarette smoking (such as Drs. Mally, Celko, and Garson here) or refer to evidence which supports a total disability opinion, may make the opinion “unreasoned.” *Gilliam v. G&O Coal Co.*, 7 B.L.R. 1-59 (1984).

There is evidence of record that claimant’s respiratory disability is due, in part, to his undisputed history of cigarette smoking. However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the “sole” or “direct” cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*).

As discussed above, the miner failed to establish the existence of coal workers’ pneumoconiosis.

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, as here, then benefits cannot be awarded. *See, Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Picklands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).³²

ATTORNEY FEES

The award of attorney’s fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has established that a material change in condition has taken place since the previous denial, because although he has not established the existence of pneumoconiosis, he has proven he is now totally disabled. The claimant has not established he has pneumoconiosis, as defined by the Act and Regulations. The claimant is totally disabled. His total disability is proven to be due to pneumoconiosis. He is therefore not entitled to benefits.

³² “By adopting the ‘necessary condition’ analysis of the Seventh Circuit in *Robinson*, we addressed those claims...in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5.” *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

ORDER³³

It is ordered that the claim of THEODORE BIONI for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that “An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607).”

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after “filing” (or **receipt by**) with the Division of Coal Mine Workers’ Compensation, OWCP, ESA, (“DCMWC”), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**³⁴

At the time you file an appeal with the Board, you **must also send a copy** of the appeal letter to **Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210.** See 20 C.F.R. § 725.481.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

If an appeal is not timely filed with the Board, the administrative law judge’s decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

³³ § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

³⁴ 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

